
Complementary and Alternative Medicine (CAM)

Purpose of Paper

The American Occupational Therapy Association, Inc. (AOTA) asserts that complementary and alternative medicine (CAM) may be used by occupational therapists and occupational therapy assistants as part of a comprehensive approach to enhance engagement in occupation (Giese, Parker, Lech-Boura, Burkhardt, & Cook, 2003). Because the use of CAMs is expanding in various health care practices, the purpose of this paper is to define the appropriate use of complementary and alternative medicine within the scope of occupational therapy practice.

Explanation of CAMs

The National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health has identified five domains of CAM practice and defines *complementary and alternative medicine* as “a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine” (NCCAM, 2002). The five domains of CAM practice are (1) alternative medical systems, (2) mind–body interventions, (3) biologically based treatments, (4) manipulative and body-based methods, and (5) energy therapies. Though the terms *complementary* and *alternative* often are interchanged, the commonly accepted distinction between them is that alternative medicine is practiced *in place of* conventional medicine, while complementary practices are accessed *in conjunction with* allopathic medical practices. The newer terms *integrative medicine* and *blended medicine* also are used to reference complementary medicine. The definition of complementary and alternative medicine is, by its very nature, dynamic. Practices contained within the definition of CAMs change as some become adopted into conventional health, and new ones emerge (Giese et al., 2003).

CAM services, though often paid for privately, increasingly are covered by insurance companies and health maintenance organizations (Astin, Pelletier, Marie, & Haskell, 2000; Cleary-Guida, Okvat, Oz, & Ting, 2001; Wolsko, Eisenberg, Davis, Ettner, & Phillips, 2002). Factors that compel third-party payers to include selected CAMs in health care policies include cost-effectiveness, consumer demand, demonstrated clinical efficacy, and state mandate (Pelletier & Astin, 2002; Pelletier, Astin, & Haskell, 1999). Further support for the use of CAMs is provided by the funding for research and training of CAM practices by the NCCAM.

Research is important to determine the efficacy and effectiveness of CAM practices in health and wellness arenas. The current number of outcomes studies for any specific CAM method is small. Research that does exist generally has limited and nonrandomized sample sizes and inconsistently defined terms, thereby reducing the power of the evidence and the ability to generalize results. Results that do exist show mixed evidence on the efficacy of CAM practices. These findings suggest the need for more studies to validate the efficacy of specific CAM practices with scientific evidence using randomized, controlled trials.

Use of CAMs Within Occupational Therapy Practice

Occupational therapists and occupational therapy assistants have used various CAM techniques in the delivery of occupational therapy services. CAMs may be used within the scope of occupational therapy practice when they are used as preparatory methods or purposeful activities to facilitate the ability of clients to engage in their daily life occupations.

Occupational therapy values engagement in occupations and has as its core mission to support participation in context (AOTA, 2002). Occupations are “activities . . . of everyday life, named, organized, and given value and meaning by individuals and a culture” (Law, Polatajko, Baptiste, & Townsend, 1997). Occupations encompass activities of daily living, instrumental activities of daily living, education, leisure skills, play, social participation, and work (AOTA, 2002). The occupational therapist is responsible for all aspects of occupational therapy service delivery and is accountable for the safety and effectiveness of the occupational therapy service delivery process. The occupational therapy assistant is responsible for providing safe and effective occupational therapy services under the supervision of and in partnership with the occupational therapist (AOTA, 2004b).

To determine whether to use CAMs in the delivery of occupational therapy services, occupational therapists and occupational therapy assistants must evaluate the client, develop an intervention based on the client’s needs and priorities, and conduct outcomes measurement. The evaluation enables the occupational therapist and the occupational therapy assistant to gain an understanding of the client’s strengths, priorities, and current limitations in carrying out daily occupations. Evaluation and intervention address factors that influence the client’s occupational performance, including how the client performs the daily life occupations, the demands of those occupations, and the environments where those occupations are performed. As part of the evaluation and the intervention, the occupational therapist and the occupational therapy assistant must determine whether the use of CAMs is consistent with the client’s cultural practices, priorities, and needs; is safe to use; and is an appropriate approach to facilitate the ability of the client to participate in daily life occupations. Outcomes are measured to determine the effectiveness of occupational therapy services and future therapeutic interventions with the client. The occupational therapist and the occupational therapy assistant must measure whether the use of CAMs resulted in positive outcomes.

Some CAM techniques currently being utilized in occupational therapy include guided imagery, massage, myofascial release, meditation, yoga, and behavioral relaxation training (Lindsay, Fee, Michie, & Heap, 1994; Scott, 1999). Because individuals receiving occupational therapy services are embedded in their cultures and because some CAM practices are embedded within particular cultures, occupational therapists and occupational therapy assistants need to understand how those cultures influence where and when to use CAM techniques. Outcome studies continue to need to be conducted to determine the efficacy and effectiveness of using CAM techniques during occupational therapy intervention to enable individuals to engage in their daily life occupations.

The *Occupational Therapy Code of Ethics* (AOTA, 2000) mandates safe and competent practice, holding occupational therapy professionals responsible for the maintenance of high standards of competence. CAM techniques used within the scope of occupational therapy practice may require additional training, competency examinations, certification, and regulatory knowledge. The use of specific CAM techniques may be subject to federal, state, and often local municipal regulations that govern practice, advertising, ethics, professional terminology, and training. It is the responsibility of the occupational therapist and the occupational therapy assistant to know and comply with applicable laws and regulations associated with CAM techniques as well as those mandated for the occupational therapy profession. Occupational therapists and occupational therapy assistants must abide by state regulations when billing for occupational therapy services that incorporate the use of CAMs. They must distinguish between when they are using CAMs within the scope of occupational therapy practice and when they are using CAMs as a primary approach beyond the scope of occupational therapy practice (AOTA, 2002, 2004a).

Issues of client safety and health care worker safety are salient to all areas of occupational therapy practice. The use of CAMs requires attention to client safety in consumer decision making, client interventions, and professional education and training. The risks and benefits of CAMs used in occupational therapy should be communicated to clients as standard practice in a client-centered, evidence-based approach to care.

Summary

Occupational therapy professionals facilitate proficient and satisfying engagement in the significant tasks and meaningful activities of life. Complementary and alternative medical practices, systems, and products may be appropriately incorporated into occupational therapy practice as a way to encourage a client's engagement in meaningful occupations. Scientific studies are needed to validate the safety and efficacy of CAM methods within occupational therapy practice. Advanced-level training and continuing education are important to acquire the knowledge and skill to utilize CAM methods, to address the concerns for patient safety and informed consent, and to meet the rigors of regulatory requirements.

References

- American Occupational Therapy Association. (2000). Occupational therapy code of ethics (2000). *American Journal of Occupational Therapy*, 54, 614–616.
- American Occupational Therapy Association. (2002). Occupational therapy practice framework: Domain and process. *American Journal of Occupational Therapy*, 56, 609–639.
- American Occupational Therapy Association. (2004a). *Definition of occupational therapy practice for the AOTA Model Practice Act*. (Available from the State Affairs Group, American Occupational Therapy Association, 4720 Montgomery Lane, Bethesda, MD 20814)
- American Occupational Therapy Association. (2004b). Guidelines for supervision, roles, and responsibilities during the delivery of occupational therapy services. *American Journal of Occupational Therapy*, 58, 663–667.
- Astin, J. A., Pelletier, K. R., Marie, A., & Haskell, W. L. (2000). Complementary and alternative medicine use among elderly persons: One-year analysis of a Blue Shield Medicare supplement. *Journals of Gerontology, Series A, Biological Sciences and Medical Sciences*, 55(1), M4–M9.
- Cleary-Guida, M. B., Okvat, H. A., Oz, M. C., & Ting, W. (2001). A regional survey of health insurance coverage for complementary and alternative medicine: Current status and future ramifications. *Journal of Alternative and Complementary Medicine*, 7, 269–273.
- Giese, T., Parker, J. A., Lech-Boura, J., Burkhardt, A., & Cook, A. (2003). *The role of occupational therapy in complementary and alternative medicine* [White Paper]. Adopted by the AOTA Board of Directors 6-22-03. (Available from American Occupational Therapy Association, 4720 Montgomery Lane, Bethesda, MD 20814.)
- Law, M., Polatajko, H., Baptiste, W., & Townsend, E. (1997). Core concepts of occupational therapy. In E. Townsend (Ed.), *Enabling occupation: An occupational therapy perspective* (pp. 29–56). Ottawa, ON: Canadian Association of Occupational Therapists.
- Lindsay, W. R., Fee, M., Michie, A., & Heap, I. (1994). The effects of cue control relaxation on adults with severe mental retardation. *Research in Developmental Disabilities*, 15, 425–437.
- National Center for Complementary and Alternative Medicine. (2002). What is complementary and alternative medicine? Retrieved July 14, 2002, from <http://www.nccam.nih.gov/health/whatiscam/>.

- Pelletier, K. R., & Astin, J. A. (2002). Integration and reimbursement of complementary and alternative medicine by managed care and insurance providers: 2000 update and cohort analysis. *Alternative Therapies in Health and Medicine*, 8(1), 38–39, 42, 44.
- Pelletier, K. R., Astin, J. A., & Haskell, W. L. (1999). Current trends in the integration and reimbursement of complementary and alternative medicine by managed care organizations (MCOs) and insurance providers: 1998 update and cohort analysis. *American Journal of Health Promotion*, 4, 125–133.
- Scott, A. H. (1999). Wellness works: Community service health promotion groups led by occupational therapy students. *American Journal of Occupational Therapy*, 53, 566–574.
- Wolsko, P. M., Eisenberg, D. M., Davis, R. B., Ettner, S. L., & Phillips, R. S. (2002). Insurance coverage, medical conditions, and visits to alternative medicine providers: Results of a national survey. *Archives of Internal Medicine*, 162, 281–287.

Additional Reading

- Bausell, R. B., Lee, W. L., & Berman, B. M. (2001). Demographic and health-related correlates to visits to complementary and alternative medical providers. *Medical Care*, 9, 190–196.
- Burkhardt, A., & Parker, J. (1998, November 26). OT perspective: Complementary care survey results. *OT Week*, 12(48), 4.
- Carlson, J. (2003). *Complementary therapies and wellness: Practice essentials for holistic healthcare*. Upper Saddle River, NJ: Prentice Hall.
- Eisenberg, D. M., Davis, R. B., Ettner, S. L., Appel, S., Wilkey, S., Van Rompay, M., et al. (1998). Trends in alternative medicine use in the United States, 1990–1997: Results of a follow-up national survey. *Journal of the American Medical Association*, 280, 1569–1575.
- Eisenberg, D. M., Kessler, R. C., Van Rompay, M. I., Kaptchuk, T. J., Wilkey, S. A., Appel, S., et al. (2001). Perceptions about complementary therapies relative to conventional therapies among adults who use both: Results from a national survey. *Annals of Internal Medicine*, 135, 344–351.
- Kaboli, P. J., Doebbeling, B. N., Saag, K. G., & Rosenthal, G. E. (2001). Use of complementary and alternative medicine by older patients with arthritis: A population-based study. *Arthritis and Rheumatology*, 45, 398–403.
- Ni, H., Simile, C., & Hardy, A. M. (2002). Utilization of complementary and alternative medicine by United States adults: Results from the 1999 national health interview survey. *Med Care*, 40, 353–358.

Author

Terry Giese, MBA, OT/L, FAOTA

for

The Commission on Practice

Sara Jane Brayman, PhD, OTR/L, FAOTA, *Chairperson*

Adopted by the Representative Assembly 2005C217

Note: This document replaces the 2003 AOTA White Paper “Complementary and Alternative Medicine.”

Copyright © 2005, by the American Occupational Therapy Association. Previously published in the *American Journal of Occupational Therapy*, 59, 653–655.